

§ 431.960

42 CFR Ch. IV (10–1–14 Edition)

Negative case means a case containing information on a beneficiary who applied for benefits and was denied or whose program benefits were terminated, based on the State agency's eligibility determination or on a completed redetermination.

Payment means any payment to a provider, insurer, or managed care organization for a Medicaid or CHIP beneficiary for which there is Medicaid or CHIP Federal financial participation. It may also mean a direct payment to a Medicaid or CHIP beneficiary in limited circumstances permitted by CMS regulation or policy.

Payment error rate means an annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

Payment review means the process by which payments for services are associated with cases reviewed for eligibility. Payments are collected for services received in the review month or in the sample month, depending on the case reviewed.

PERM means the Payment Error Rate Measurement process to measure improper payment in Medicaid and CHIP.

Provider means any qualified provider recognized under Medicaid and CHIP statute and regulations.

Provider error includes, but is not limited to, medical review errors as described in § 431.960(c) of this subpart, as determined in accordance with documented State or Federal policies or both.

Review cycle means the complete timeframe to complete the improper payments measurement including the fiscal year being measured; generally this timeframe begins in October of the fiscal year reviewed and ends in August of the following fiscal year.

Review month means the month in which eligibility is reviewed and is usually when the State took its last action to grant or redetermine eligibility. If the State's last action was taken beyond 12 months prior to the sample month, the review month shall be the sample month.

Review year means the Federal fiscal year being analyzed for errors by Federal contractors or the State.

Sample month means the month the State selects a case from the sample for an eligibility review.

State agency means the State agency that is responsible for determining program eligibility for Medicaid and CHIP, as applicable, based on applications and redeterminations.

State error includes, but is not limited to, data processing errors and eligibility errors as described in § 431.960(b) and (d) of this subpart, as determined in accordance with documented State or Federal policies or both.

States means the 50 States and the District of Columbia.

Undetermined means a beneficiary case subject to a Medicaid or CHIP eligibility determination under this regulation about which a definitive determination of eligibility could not be made.

[71 FR 51081, Aug. 28, 2006, as amended at 75 FR 48847, Aug. 11, 2010]

§ 431.960 Types of payment errors.

(a) *General rule.* State or provider errors identified for the Medicaid and CHIP improper payments measurement under the Improper Payments Information Act of 2002 must affect payment under applicable Federal policy or State policy or both.

(b) *Data processing errors.*

(1) A data processing error is an error resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System, related systems, or outside sources of provider verification.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with the State's documented policies, is the dollar measure of the payment error.

(3) Data processing errors include, but are not limited to the following:

(i) Payment for duplicate items.

(ii) Payment for non-covered services.

(iii) Payment for fee-for-service claims for managed care services.

(iv) Payment for services that should have been paid by a third party but were inappropriately paid by Medicaid or CHIP.

(v) Pricing errors.

(vi) Logic edit errors.

(vii) Data entry errors.

(viii) Managed care rate cell errors.

(ix) Managed care payment errors.

(c) *Medical review errors.* (1) A medical review error is an error resulting in an overpayment or underpayment that is determined from a review of the provider's medical record or other documentation supporting the service(s) claimed, Code of Federal Regulations that are applicable to conditions of payment, the State's written policies, and a comparison between the documentation and written policies and the information presented on the claim.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with 42 CFR 440 to 484.55 of the Code of Federal Regulations that are applicable to conditions of payment and the State's documented policies, is the dollar measure of the payment error.

(3) Medical review errors include, but are not limited to the following:

(i) Lack of documentation.

(ii) Insufficient documentation.

(iii) Procedure coding errors.

(iv) Diagnosis coding errors.

(v) Unbundling.

(vi) Number of unit errors.

(vii) Medically unnecessary services.

(viii) Policy violations.

(ix) Administrative errors.

(d) *Eligibility errors.* (1) An eligibility error includes, but is not limited to, errors determined by applying Federal rules and the State's documented policies and procedures, resulting from services being provided to an individual who meets at least one of the following provisions:

(i) Was ineligible when authorized as eligible or when he or she received services.

(ii) Was eligible for the program but was ineligible for certain services he or she received.

(iii) Lacked or had insufficient documentation in his or her case record, in accordance with the State's docu-

mented policies and procedures, to make a definitive review decision of eligibility or ineligibility.

(iv) Overpaid the assigned liability due to the individual's liability being understated.

(v) Underpaid toward assigned liability due to the individual's liability being overstated.

(vi) Was ineligible for managed care but enrolled in managed care.

(vii) Was eligible for managed care but improperly enrolled in the incorrect managed care plan.

(2) The dollars paid in error due to the eligibility error is the measure of the payment error.

(3) A State eligibility error does not result from the State's verification of an applicant's self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant's self-declaration or self-certification satisfies the requirements in Federal law, guidance, or if applicable, Secretary approval.

(4) Negative case errors are errors, based on the State's documented policies and procedures, resulting from either of the following:

(i) Applications for Medicaid or CHIP that are improperly denied by the State.

(ii) Existing cases that are improperly terminated from Medicaid or CHIP by the State.

(5) No payment errors are associated with negative cases.

(e) *Errors for purposes of determining the national error rates.* The Medicaid and CHIP national error rates include but are not limited to the errors described in paragraphs (b) through (d) of this section, with the exception of negative case errors described in paragraph (d)(4) of this section.

(f) *Errors for purposes of determining the State error rates.* The Medicaid and CHIP State error rates include but are not limited to, the errors described in paragraphs (b) through (d)(1)(vii) of this section, with the exception of negative case errors as described in paragraph (d)(4) of this section.

(g) *Error codes.* CMS may define different types of errors within the above categories for analysis and reporting

§ 431.970

purposes. Only dollars in error will factor into a State's PERM error rate.

[75 FR 48848, Aug. 11, 2010]

§ 431.970 Information submission requirements.

(a) States must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and CHIP, that include but are not limited to—

(1) Adjudicated fee-for-service (FFS) or managed care claims information or both, on a quarterly basis, from the review year;

(2) Upon request from CMS, provider contact information that has been verified by the State as current;

(3) All medical and other related policies in effect and any quarterly policy updates;

(4) Current managed care contracts, rate information, and any quarterly updates applicable to the review year for CHIP and, as requested, for Medicaid;

(5) Data processing systems manuals;

(6) Repricing information for claims that are determined during the review to have been improperly paid;

(7) Information on claims that were selected as part of the sample, but changed in substance after selection, for example, successful provider appeals;

(8) Adjustments made within 60 days of the adjudication dates for the original claims or line items with sufficient information to indicate the nature of the adjustments and to match the adjustments to the original claims or line items;

(9) For the eligibility improper payment measurement, information as set forth in §§ 431.978 through 431.988;

(10) A corrective action plan for purposes of reducing erroneous payments in FFS, managed care, and eligibility; and

(11) Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining error rates in Medicaid and CHIP.

(b) Providers must submit information to the Secretary for, among other purposes estimating improper payments in Medicaid and CHIP, which include but are not limited to, Medicaid

42 CFR Ch. IV (10–1–14 Edition)

and CHIP beneficiary medical records within 75 calendar days of the date the request is made by CMS. If CMS determines that the documentation is insufficient, providers must respond to the request for additional documentation within 14 calendar days of the date the request is made by CMS.

[71 FR 51081, Aug. 28, 2006, as amended at 72 FR 50513, Aug. 31, 2007; 75 FR 48848, Aug. 11, 2010]

§ 431.972 Claims sampling procedures.

(a) *Claims universe.* (1) The PERM claims universe includes payments that were originally paid (paid claims) and for which payment was requested but denied (denied claims) during the FFY, and for which there is FFP (or would have been if the claim had not been denied) through Title XIX (Medicaid) or Title XXI (CHIP).

(2) The State must establish controls to ensure FFS and managed care universes are accurate and complete, including comparing the FFS and managed care universes to the Form CMS-64 and Form CMS-21 as appropriate.

(b) *Sample size.* CMS estimates a State's annual sample size for claims review at the beginning of the PERM cycle.

(1) *Precision and confidence levels.* The annual sample size should be estimated to achieve a State-level error rate within a 3 percent precision level at 95 percent confidence interval for the claims component of the PERM program, unless the precision requirement is waived by CMS on its own initiative.

(2) *Base year sample size.* The annual sample size in a State's first PERM cycle (the "base year") is—

(i) Five hundred fee-for-service claims and 250 managed care payments drawn from the claims universe; or

(ii) If the claims universe of fee-for-service claims or managed care capitation payments from which the annual sample is drawn is less than 10,000, the State may request to reduce its sample size by the finite population correction factor for the relevant PERM cycle.

(3) *Subsequent year sample size.* In PERM cycles following the base year:

(i) CMS considers the error rate from the State's previous PERM cycle to determine the State's annual sample size for the current PERM cycle.